



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586

Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Proton Pump Inhibitor Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Aciphex, Nexium, Protonix, prescription omeprazole formulations and brand-name multiple-source proton pump inhibitors that have an FDA "A"-rated generic equivalent. PA is required for Prevacid for members older than 16 years (except for use of Prevacid suspension for members in long-term-care facilities). Prilosec OTC does not require PA. Additional information about PPI use can be found within the MassHealth Drug List at www.mass.gov/druglist.

Member information

Last name	First name	MI	MassHealth member ID #	Date of birth	Sex (Circle one.) f m
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

Indication for proton pump inhibitor

<input type="checkbox"/> GERD <input type="checkbox"/> Moderate-severe erosive esophagitis <input type="checkbox"/> Uncomplicated non erosive esophagitis Has an H ₂ antagonist previously been tried? <input type="checkbox"/> Yes. State drug name, dose, frequency, and duration. _____ _____ <input type="checkbox"/> No. Explain why not. _____ _____ <input type="checkbox"/> Barrett's esophagus or esophageal strictures <input type="checkbox"/> GERD in child with one of the following conditions: <input type="checkbox"/> Severe chronic respiratory disease (specify): _____ _____ <input type="checkbox"/> Neurologic disability (specify): _____ _____ <input type="checkbox"/> Other (specify): _____ _____ <input type="checkbox"/> Condition associated with extraesophageal symptoms secondary to gastric reflux <input type="checkbox"/> Non cardiac chest pain <input type="checkbox"/> Asthma <input type="checkbox"/> Idiopathic hoarseness <input type="checkbox"/> Chronic laryngitis <input type="checkbox"/> Other (explain): _____ _____ <input type="checkbox"/> other (explain): _____	<input type="checkbox"/> Duodenal ulcer <input type="checkbox"/> Gastric ulcer <input type="checkbox"/> Helicobacter pylori: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Drug-induced: <input type="checkbox"/> Treatment: List causative agent(s): _____ _____ <input type="checkbox"/> Prevention: List risk factor(s): _____ _____ <input type="checkbox"/> Other cause (specify): _____ _____ <input type="checkbox"/> Non-ulcer or functional dyspepsia Has an H ₂ antagonist previously been tried? <input type="checkbox"/> Yes. State drug name, dose, frequency, and duration. _____ _____ <input type="checkbox"/> No. Explain why not. _____ _____ <input type="checkbox"/> Pathological hypersecretory syndromes <input type="checkbox"/> Zollinger-Ellison syndrome <input type="checkbox"/> MEN Type I <input type="checkbox"/> Other: _____
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Diagnostic studies performed (include dates of studies)

Describe any diagnostic studies performed, including dates of studies.

Medication information

Important Note: For maximum efficacy, a proton pump inhibitor (PPI) must be taken in a fasting state, just before or with breakfast. If a second dose is necessary, the second dose should be given just before the evening meal. In general, it is not necessary to prescribe other antisecretory agents (H₂ antagonists, prostaglandins) for patients on PPIs. If an antisecretory agent is prescribed with a PPI, the PPI should not be taken within six hours of the antisecretory agent.

PPI requested	Dose, frequency, and duration of PPI	Drug or service code
Has member tried Prilosec OTC? (Note: Prilosec OTC does not require prior authorization.)		
<input type="checkbox"/> Yes. Provide the following information about the use of Prilosec OTC.		<input type="checkbox"/> No. Explain why not.
Dates of use	Dose and frequency	
If member received Prilosec OTC, why was it discontinued? (Check one or all that apply.)		
<input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Intolerance <input type="checkbox"/> Other		
Details of adverse reaction, inadequate response, intolerance, or other: _____		

Pharmacy information

Name	Pharmacy provider no.	Telephone no.	Fax no.
	<i>Optional</i>	()	() <i>Optional</i>
Address	City	State	Zip
			<i>Optional</i>

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State Zip
E-mail address			Telephone no.	Fax no.
<i>Optional</i>			()	()

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.)

Date